State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
BOARD OF PODIATRIC MEDICINE
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Information on Privileging

The Federation of Podiatric Medical Boards recommends in the introduction to its *Model Law* [http://www.fpmb.org/modellaw.asp] that:

> DPMs like other doctors should be privileged based on demonstrated training and competence. They should not be granted privileges automatically for the full scope of their license, nor may they be arbitrarily denied a privilege because of their degree if the procedure is within their legal scope of practice under state law.

Introduction

This Board of Podiatric Medicine (BPM) fact sheet may be read together with others in this series [http://bpm.ca.gov/pubs/index.htm] such as *Information for Health Facilities* and *Information on Scope of Practice*.

BPM enforces the scope of practice, the State Medical Practice Act's competency requirements, other applicable laws and the professions' standard of care. Health facilities play an equally important role through privileging, peer review, and reporting to the Medical Board.

For some years, BPM has referred inquiries about surgical privileging to the American College of Foot and Ankle Surgeons (ACFAS). Its most recent, June 2004 *Position Statement: Credentialing for Podiatric Foot & Ankle Surgeons* may be requested from ACFAS [http://www.acfas.org/].

While BPM is often asked about privileging criteria, the Board has no regulatory authority in this area. This fact sheet is informational and reflects professional standards and current practices in well-administered facilities. Health facilities are regulated by the Department of Health Services under the Health and Safety Code, which grants it authority to prosecute illegal discrimination against DPMs [see http://bpm.ca.gov/pubs/fsdiscrm.htm].

JCAHO guidelines specify evidence of current license, current competence, and relevant training and ability to perform privileges requested. The ACFAS utilizes three categories. BPM drew the qualifying criteria suggested herein from the professional literature as general guidelines to be applied flexibly but responsibly. Because DPMs are a small specialty, medical administrators may be less familiar with their credentials. The Board welcomes inquiries, which may be directed to its executive officer at 916-263-2650 or by e-mail [Jim_Rathlesberger@dca.ca.gov].

Residency Requirements

Postgraduate training first became available to a limited number of DPMs in the 1950s. One year became a California licensure requirement in 1983, but recognizing the shortage of programs the statute allowed preceptorships to be substituted through 1986. BPM-sponsored legislation (SB 1775, Statutes of 1994, Chapter 1206) required all DPM residencies to include surgical training as of January 1, 1998. The national Council on Podiatric Medical Education (CPME) amended its standards to the same effect in 1997. In 1995, the American Podiatric Medical Association defined entry-level training to require two years of podiatric medical and surgical residency. In 2003, CPME adopted new standards transitioning all residencies into two categories: a two-year Podiatric Medicine and Surgery (PM&S-24), and a three-year Podiatric Medicine and Surgery (PM&S-36) [http://www.apma.org/cpme/]. Pending California legislation would require two years of residency prior to licensure beginning in 2005.

Categories & Criteria

In privileging, health facilities should apply current residency and certification standards to new graduates, recognizing that these will continue to evolve. Current staff should not be re-privileged on new criteria, but renewed in the normal review process based on evaluation of their surgical experience and continuing competence.

For new applicants lacking a Podiatric Surgical Residency (PSR) or PM&S, facilities may consider clinical experience at other facilities, operating room reports, residency training logs, postgraduate workshops/symposia/fellowships, continuing education, continuing competence indicators, scholarly achievement, letters of documentation from training directors, and verification from collateral sources. In 1995, BPM distributed guidelines suggesting the surgical proficiency of new graduates from non-surgical residencies [i.e., Podiatric Orthopedic (POR), Rotating Podiatric (RPR), and Primary Podiatric Medical (PPMR)] would generally be limited to procedures such as excision/biopsy cutaneous lesions, interphalangeal joint arthroplasty, matrixectomy, tenotomy and capsulotomy (toe), repair of simple laceration/wound, and partial ostectomy (toe). For such applicants, additional privileges should be based on documentation such as that suggested above.

An applicant may be granted privileges for additional podiatric procedures not specifically identified below, or selected procedures above his/her category level, given documentation of experience and competence.

Category I. -- Digital and Forefoot

- One year of postgraduate training approved by the Council on Podiatric Medical Education
- Board qualified or certified in foot surgery, American Board of Podiatric Surgery (ABPS)

Category II. -- Forefoot, Midfoot & Simple Rearfoot

- Two years of CPME-approved residency training (at least 12 months in surgical residency)
- Board qualified or certified in foot surgery, ABPS

Category III. -- Rearfoot and Ankle

- Three years of CPME-approved residency (at least 24 months in surgical residency), or two years supplemented by fellowship training
- Board qualified or certified in reconstructive rearfoot/ankle surgery, ABPS

Guidelines for Surgical Privileging

(*Based on American College of Foot and Ankle Surgeons' 10/21/2000 Guidelines*)

Applicant: Check the REQ (requested) item for procedures for which you are requesting privileges. If this is a supplemental upgrade request, check only those additional privileges requested with supporting documentation.

A surgeon may be granted partial privileges in any category listed below with appropriate documentation.

Credentials Committee: Check APP for approval.

Applicant's Name: _____ Date: _____

Type: ( ) New Applicant ( ) Supplemental Upgrade

Category I. -- Digital and Forefoot	REQ	APP
Capsulotomy/Tenotomy Digital M-P Joints	( )	( )
Digital Surgery	( )	( )
Osteotomy & Ostectomy	( )	( )
Soft Tissue Repairs & Excisions - Digits & Forefoot	( )	( )
Fractures of Digits & Metatarsals – (ORIF or Closed)	( )	( )
Laser Surgery	( )	( )

Category II. -- Forefoot, Midfoot and Simple Rearfoot		
Simple Bunionectomy	( )	( )
Hallux Valgus with Osteotomy	( )	( )
Prosthesis of Great Toe Joint	( )	( )
Metatarsal Osteotomy & Ostectomies	( )	( )
Excision of Soft Tissue Neoplasms, Foot	( )	( )
Fasciotomy, Plantar (Simple, Steindler)	( )	( )
Midfoot Osteotomies & Arthrodesis	( )	( )
Ostectomies of the Midfoot & Rearfoot	( )	( )
Neurolysis of the Foot	( )	( )
Amputations of the Digits & Forefoot	( )	( )
Fractures of the Forefoot & Midfoot (ORIF or Closed)	( )	( )
Forefoot Arthroplasty - Head/Base Excisions	( )	( )
Osteomyelitis Management of the Forefoot	( )	( )
Bone Graft Harvest from Foot	( )	( )
Extracorporeal Shock Wave Therapy	( )	( )

Category III. -- Rearfoot and Ankle

Flatfoot Reconstruction with Osteotomy, Bone Grafts, etc. ..... ( ) ( )
Cavus Foot Reconstruction with Osteotomy, Fusions, etc. ..... ( ) ( )
Major Tendon Transfers Lengthening & Repair of the Foot & Leg ..... ( ) ( )
Ligmentoplastic Repair or Ankle Stabilization..... ( ) ( )
Arthroereisis, with Implants, Hindfoot & Ankle ..... ( ) ( )
Major Rearfoot Arthrodesis - Triple, Subtalar..... ( ) ( )
Fractures of the Rearfoot - Tarsals (ORIF & Closed Reductions) ..... ( ) ( )
Ankle Fractures (ORIF & Closed Reductions) ..... ( ) ( )
Ankle Arthrodesis ..... ( ) ( )
Ankle Arthroplasty with Prosthesis ..... ( ) ( )
Ankle Arthroplasty without Prosthesis ..... ( ) ( )
Osteomyelitis Management - Hindfoot, Ankle ..... ( ) ( )
Flaps/Skin Grafts..... ( ) ( )
I&D, Debridement of Foot & Ankle Infections ..... ( ) ( )
Neurolysis and Neurectomy of the Ankle ..... ( ) ( )
Excision of Soft Tissue Neoplasms ..... ( ) ( )
Clubfoot and Vertical Talus Release/Reconstruction..... ( ) ( )
Hindfoot & Ankle Osteotomies & Cartilage Repair ..... ( ) ( )
Foot and Ankle, Arthroscopy (Diagnostic/Surgical) ..... ( ) ( )
Excision of Malignant Neoplasms of the Foot and Ankle..... ( ) ( )
Amputations – Midfoot ..... ( ) ( )
Osteotomy – Ankle ..... ( ) ( )
Release of nerve entrapment..... ( ) ( )
Treatment of Vascular Conditions using Injection, Laser, Electrosurgical
Or Surgical Excision ..... ( ) ( )
Other(s), Not Listed:
.... ( ) ( )
..... ( ) ( )
..... ( ) ( )

_____
Chair, Department or Section

_____
Chair, Credentials Committee

Date of Review _____

Comments:
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